Sustainability of a Community-Based Mother-to-Mother Support Project In the Peri-Urban Areas Of Guatemala City

A La Leche League Study

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BASICS

LA LECHE LEAGUE INTERNATIONAL

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Abstract

The sustainability study of La Leche League of Guatemala's community-based mother-to-mother support project for breastfeeding promotion and support in the peri-urban areas of Guatemala City posed three questions. (1) In what sense has the program been sustained during the postgrant period (1993–96)? (2) What factors have contributed to its sustainability? and (3) Can La Leche League International establish norms to ensure sustainability of its programs? The data show that the project has been sustained at nearly the same level as during the grant period. Although fewer trained breastfeeding counselors are reporting to LLLG or running support groups, they continue to give individual counseling and refer mothers and children to clinics. Key factors in this success are high personal motivation of various participants in the project and the six-level support structure that provides bidirectional support and motivation across the levels. The participation and decision-making at the community level and monthly and annual workshops and refresher training are other vital elements for sustaining the program. Other key observations are (1) the prominent perceived need by community women is physical and economic survival—not health; and (2) coordination with the local health system is valuable and needs further development.

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Contents

Figures and Tables

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Acronyms

ARI	acute respiratory infection
BASICS	Basic Support for Institutionalizing Child Survival
BC	breastfeeding counselor
CEPREN	Centro de Promocion y Estudios en Nutricion
CLDS	Church of Jesus Christ of Latter-day Saints
LLLG	La Leche League Guatemala
LLLI	La Leche League International
NGO	nongovernmental organization
PVO	private voluntary organization
USAID	U.S. Agency for International Development
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1. Technical Review and Analysis

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La Leche League has started up, been sustained, and often prospered in many developed and underdeveloped countries. While La Leche League generally relies on educated, middle-class mothers for membership and leadership, leagues in some countries have developed programs that reach into the lower socioeconomic segments of the population to involve local low-income mothers in promoting and supporting breastfeeding and other child health practices in their own communities. The question is whether these programs have worked. Are they reaching a substantial proportion of the needy low-income mothers? Are they sustainable? Do they make a difference?

Program Description

Guatemala is one of the countries where La Leche League developed a program for low-income mothers. In 1988 La Leche League International (LLLI) and La Leche League Guatemala (LLLG) initiated a project to establish a community network of mother-to-mother support in poor peri-urban areas of Guatemala City with funding from a U.S. Agency for International Development (USAID) child survival grant. During the four years of the grant project, 214 breastfeeding counselors (BCs) from the peri-urban areas were trained and supervised at a cost of $190,000. The BCs provided one-on-one counseling to other women in the area, referred them and their children to nearby health clinics, and ran mother support groups, all on a volunteer basis with no financial reward of any sort. LLLG staff received monthly reports from the BCs, made visits to the low-income communities, held monthly meetings and mini-workshops with the BCs, and carried out myriad required administrative tasks, all in addition to the initial BC training and establishment of programs in the communities.

In 1992, as the end of the grant funding approached, a meeting of BCs and LLLG staff discussed the future of the program. Seven of the 10 program communities were well represented at the meeting and decided to continue the program. The BCs from each of those seven communities selected a “coordinator” and “subcoordinator” from their own ranks to act as their leaders and represent them to the program. For its part, LLLG agreed to continue to provide support to the program with monthly meetings and mini-workshops for the coordinators, maintain the information system, and provide overall coordination, but with a greatly reduced staff. These commitments were implemented and for the most part have been maintained to the present. One of the seven communities dropped its coordinator; no new BCs were trained, and no new community programs were established. Previous reports document the details of the program and discuss its continuation beyond the grant period.[1]

Study Methodology

In 1996 LLLG undertook a study of the sustainability of the Guatemala peri-urban project with funding from BASICS. The study focused on three questions: In what sense has the

program been sustained? What factors have contributed to the program's sustainability? Can LLLI establish norms that systematically promote sustainability of its programs? The study, reported in detail in section 2, is summarized here and the results analyzed with respect to its cost-effectiveness and sustainability.

The sustainability study obtained three types of data: (1) a household survey of a sample of women living in one community (El Limón) within the program area; (2) a structured interview with as many of the original BCs as could be located; and (3) administrative and financial data from LLLG records. The household survey data were used to ascertain the coverage of the program—what proportion of the women in El Limón were in contact with BCs and received services from them? The BC interview data were used to ascertain the patterns of activity and productivity among the BCs and to identify factors that might enhance program sustainability and productivity. The administrative and financial data were used to describe the nature and magnitude of the support and supervisory system provided by LLLG to the BCs and the communities during the postgrant period.

El Limón, a community of about 12,000, was selected as the site of the household survey because it was fairly typical and because it has one of the highest concentrations of BCs of all the project communities. A census of households in 50 of the 83 "blocks" in El Limón[2] yielded information from 501 women between the ages of 15 and 49 years, 217 of whom were pregnant or with a child under 2 years of age (the priority group for the BCs), and 284 others with older children or none. Structured interviews were obtained with 102 of the 141 BCs who were trained and participated in the LLLG program; the remaining 39 had moved away and 1 had died.[3]

Findings on Structure, Supervision, and Support

The structure of the program can be characterized by six levels: (1) women in the community who are not in contact with BCs; (2) women in the community who are in contact with the BCs; (3) the BCs; (4) the coordinators and subcoordinators; (5) LLLG and the paid program staff; and (6) LLLI and its associated country leagues. The study shows that support flows in both directions across these levels and that each of these levels provides support to the adjacent levels on both sides and in some cases two levels away. For example, the BCs are motivated and sustained by the women they serve, by the coordinators they selected, and by the LLLG organization, while at the same time they provide valuable services to many women in the community and motivate the continued commitment of the coordinators and LLLG. The BCs report that they receive valuable support from the coordinators and LLLG; 83% of the BCs reported feeling support from LLLG. Another example: 65% of the women in contact with a BC have taken it upon themselves to counsel other women in the community about breastfeeding and health (the so-called "ripple effect"), thus establishing the support link between the first two levels of the structure.

In 1992, just before the grant funding ended, the program was operating in 10 communities without coordinators, with approximately 141 BCs (although not all 141 were operating mother support groups), 7 paid LLLG staff devoting half their time to the project, and an annual budget of about $50,000. The LLLG staff provided all supervision of the BCs with field visits, monthly meetings, mini-workshops, and a reporting and information system. Following the

transition period in 1992–93, the program has continued to operate in seven communities, with a total of six to seven coordinators, three to five subcoordinators, an LLLG staff of only three individuals at 40% time, and an annual budget of about $20,000. Most of the 141 BCs continued to function (but not evenly) in all 10 original communities, as discussed in more detail later. The LLLG staff continued to operate the reporting and information system with data collected by the coordinators and run monthly mini-workshops for coordinators and sub-coordinators (but not for BCs). Although field visits by LLLG staff were sharply curtailed as coordinators took more responsibility for supporting the BCs, LLLG continued to hold monthly on-site meetings with BCs in the communities and run an annual workshop for all the BCs.

Findings on Services Provided

Reporting and Nonreporting BCs

Following the termination of the grant, some of the BCs continued to report monthly through their coordinators while others did not. LLLG assumed that the nonreporting BCs were no longer active. One of the big surprises from the structured interviews with BCs is that this assumption is wrong. The nonreporting BCs are still actively promoting breastfeeding and child health through individual counseling and referrals, although most are not running mother-to-mother support groups. The nonreporting BCs are spending about half as much time on breastfeeding promotion activities as the reporting BCs. Table 1-1 shows the proportion of reporting and nonreporting BCs who provided various types of services in the three months, or in the case of support groups, in the 12 months prior to the interviews. The BCs spend a little more than one-half day per week on their BC activities on average, although the variance among BCs is very high and the figures for average time per week in Table 1-1 exclude four reporting BCs who said they spend over 100 hours per month.

Table 1-1. Services Provided by BCs

Type of Service (Prior 3 Months)	Reporting BCs (N = 45)		Nonreporting BCs (N = 57)		All BCs (N= 102)	
	% of BCs Providing	Avg. Times per Month*	% of BCs Providing	Avg. Times per Month*	% of BCs Providing	Avg. Times per Month*
1. Counseling	42/45 =93%	30.0	44/57 =77%	18.0	84%	23.9
2. Home visit	38/45 =84%	9.7	21/57 =37%	12.3	58%	10.6
3. Clinic referral	34/45 =76%	8.7	35/57 =65%	4.3	71%	6.5
4. Support group (prior 12 mos.)	34/45 =76%	Not collected	7/57 =12%	Not collected	40%	Not collected
5. Average hours/ week/BC	5.3 (N=35)		3.0 (N=45)		4.2 (N=80)	

* Average number of times the service was provided per month by each BC who *provided* service in last three months.

Characteristics

The BCs are mature women with families; the average age is 43 years, and the average number of children is 4.1. Most (88%) are literate and 61% have completed primary school. They are active: 51% are engaged in part-time paid work and 69% are involved in other volunteer activities. As one observer noted, "The BCs are powerhouse women." The reporting and nonreporting BCs are similar in many ways (same age, family size, proportion working), but differ in two important characteristics: the nonreporting BCs are less involved in other voluntary activities than the reporting BCs (56% vs. 84%), but are more literate (91% vs. 84%) and more have completed primary school (69% vs. 48%).

Factors Influencing Continuing Effort of BCs

What factors motivate BCs to continue their mother-to-mother support work with LLLG? In the structured interviews, 63% said they liked teaching and giving advice, by far the most frequent response. In general, they were motivated by the process of interacting with women and being generally useful in the community rather than by the idea of achieving particular results such as reducing the use of baby bottles. Many of the nonreporting BCs said they gave up running support groups because they needed the time for other activities, such as other (paid) work (44%), caring for their own children (9%), or sickness (9%). Only 7% said the reason they did not continue to report and operate support groups was because they lost contact with their BC colleagues or LLLG. However, a much higher proportion of the reporting BCs felt there was support from LLLG and the coordinators than did nonreporting BCs, as shown in Table 1-2. From these data, it seems that BCs stop reporting for personal reasons such as the need to work, and then lose their sense of support from LLLG and coordinators.

Further, an analysis by community indicates that the presence of a coordinator was an important factor in maintaining the activity level of BCs. When communities with coordinators are compared with communities without coordinators, the BCs in the former are much more likely to continue reporting (60% vs. 3%), run support groups (53% vs. 7%), and feel supported by LLLG (83% vs. 11%). On the other hand, communities that are left without a coordinator stop having support groups and stop reporting to LLLG.

Table 1-2. BCs Who Felt There Was Support from LLLG and the Coordinators

Support Received From	Reporting BCs	Nonreporting BCs	All BCs
LLLG	98%	58%	83%
Coordinators	74%	42%	61%

Findings on Services Received: Coverage in El Limón

The household survey found that the BCs were in contact with about 25% of all women of child-bearing age in the household sample. There was no apparent socioeconomic difference between women in contact and not in contact with a BC, and very little difference in coverage between the priority group (pregnant women and mothers with children under 2 years of age) and all women of child-bearing age. Table 1-3 presents the proportion of women in the El Limón survey receiving different types of services from a BC in the three months before the survey. Most of the clinic referrals in rows 2 and 3 of the table were for well-baby or prenatal care or for infectious diseases. The survey discovered that 90% of the women who were referred followed the advice of the BC and actually went to a clinic, demonstrating the credibility of BCs in the community.

Table 1-3. Coverage: Services Received by Women in Last Three Months in the El Limón Survey

Type of Service	Pregnant or Child <2 Yrs. (N = 216)		Other Women 15–49 Years (N= 283)		All Women 15–49 Years (N= 499)	
	Fraction Covered	As % of Contacted	Fraction Covered	As % of Contacted	Fraction Covered	As % of Contacted
1. In contact with a BC	56/216 = 26%	100%	69/283 = 24%	100%	125/499 = 25%	100%
2. Child referred to clinic	40/216 = 19%	40/56 = 71%	41/283 = 14%	41/69 = 59%	81/499 = 16%	81/125 = 65%
3. Woman referred to clinic	33/216 = 15%	33/56 = 59%	34/283 = 12%	34/69 = 49%	66/499 = 13%	66/125 = 53%
4. Visited at home by BC	31/216 = 14%	31/56 = 55%	36/283 = 13%	36/69 = 52%	67/499 = 13%	67/125 = 54%
5. Attended support group	17/216 = 8%	17/56 = 30%	39/283 = 14%	39/69 = 57%	5/499 = 11%	55/125 = 44%
6. Average times attended support group in last 12 mos.	3.5		7.0		6.0	

Note: The women referred to clinics in row 3 were either pregnant themselves or mothers of pregnant daughters.

Toward an Estimate of Cost-Effectiveness

Systematic data were not obtained that link services received to particular BCs and, therefore, reliable estimates of population-based productivity are not possible, but estimates of service ratios can be made for the El Limón study area by assuming that all the services received in that area were provided by the BCs who reside there. The El Limón study area has a population of about 7,200, including 675 women aged 15–49 years and 15 resident BCs, yielding one resident BC for every 45 women of child-bearing age or, alternatively, one BC per 480 population. This preliminary result does not imply a linear relationship between the number of BCs and the population covered, nor that the same coverage ratio can be achieved in other types of communities. Nevertheless, it does provide one data point about this important relationship.

However, if linearity is assumed by extending the El Limón coverage per BC to the other BCs in the Guatemala program, then the program reaches 1,075 to 1,493 women of child-bearing age, depending on whether there are 102 BCs (the number interviewed) or 141 BCs (the number trained for the LLLG project) in the program. This yields an estimated annual cost of $13.40–$18.60 per woman covered, assuming the entire LLLG budget of $20,000 is devoted to the peri-urban program. However, this overestimates the actual cost per woman covered because part of the LLLG budget is used for other activities and because it does not include mothers counseled by other non-BC mothers (the “ripple effect”). Furthermore, the LLLG staff agreed that the current budget is sufficient to maintain a substantially larger number of BCs in the current seven communities, but adding more communities would require additional resources to maintain the same level of support from LLLG. In other words, the cost per woman covered could be reduced substantially by increasing the concentration of BCs in the current program communities. This observation by the staff is further insight into the nonlinear nature of the productivity function relating resources to results.

Conclusion

Following the end of the grant in early 1993, the LLLG peri-urban program has been sustained at nearly the same level of service as before for over three years with an internally generated annual budget of about $20,000. In the most successful communities, the program is reaching about 25% of the women aged 15–49 years. Although the number of BCs reporting to LLLG and the number of their mother-to-mother support groups has decreased since 1993, the nonreporting BCs are still actively involved in individual counseling of women and, as a result, the proportion of women receiving counseling and referrals to clinics has generally been sustained at previous levels. The community women participating in the program have also maintained a high level of contact with other women in the community about breastfeeding.

Previous studies in other countries[4] have shown that similar mother-to-mother support programs yield significant increases in the prevalence and duration of breastfeeding, including exclusive breastfeeding during the first six months of life, which in turn reduces morbidity, mortality, and fertility.

Two factors appear to be key to this success: the high personal motivation of the various participants (the mothers, the BCs, and the LLLG volunteers and staff) and the six-level support structure (participating and nonparticipating women, BCs, coordinators, LLLG, LLLI) that provides bidirectional support and motivation across the levels. Vital components of the program include the recruitment of respected and motivated women as BCs, coordinators selected by the BCs, and the monthly and annual workshops for coordinators and BCs. Other key observations are (1) the prominent perceived need by community women is physical and economic survival—not health; and (2) good coordination with local health facilities and authorities is very valuable to the success and sutainability of the project and needs additional development.

Notes

1. (a) Bezmalinovic B. and Lundgren R. 1991. The La Leche League in Guatemala: An Evaluation of LLLG Activities. DataPro, Guatemala City. (b) La Liga de la Leche Materna de Guatemala. 1995. Trabajo Comunitario en las Areas Periurbanas de la Ciudad de Guatemala. La Leche League of Guatemala, Guatemala City, and Wellstart International, San Diego. (c) Maza, I Ch. de, Magalhaes, R., and Stone-Jimenez, M. 1994. Sustainability of breastfeeding mother support groups in Guatemala. In: Storms, D., Carter, C., and Altman, P. (eds). *Community Impact of PVO Child Survival Efforts: 1985–1994*. Proceedings of a worldwide conference sponsored by USAID, Bangalore, Kanataka, India, October 2–7, 1994. Baltimore, Md.: The Johns Hopkins University School of Hygiene and Public Health. PVO Child Survival Support Program, pp. 67–70.

2. The El Limón census did not include households in nearby squatter settlements, but did include 22 women interviewed at the local marketplace, some of whom came from the squatter settlements. The survey results for the women interviewed at the market were similar to the others in the survey.

3. Although 214 women received BC training during the project grant period, only 141 actually became BCs in the LLLG project; 68 were part of programs operated by the Salvation Army or the Church of Jesus Christ of Latter-day Saints and 5 did not participate in any program.

4. The positive impact of community-based mother-to-mother support groups on breastfeeding practice has been documented in Honduras and Mexico. The Honduras experience is documented by Lundgren, R., et al. in The promotion of breastfeeding and birth spacing in rural areas, as reported in Baker J. *Promotion of Exclusive*

Breastfeeding: A Review of Experience from the Field. Nurture/Center to Prevent Childhood Malnutrition, June 1996; and the Mexico experience is documented in Morrow, A.L., Lourdes Guerro, M., Calva, J.J., Morrow, R.C., Lakkis, H.D., Bravo, J., and Butterfoss, F.D. 1996. The effectiveness of home-based counseling to promote exclusive breastfeeding among Mexican mothers. In: Wellstart International. *Exclusive Breastfeeding Promotion: A Summary of Findings from EPB's Applied Research Program (1992–1996)*, pp. 12–17. The impact of breastfeeding on morbidity, mortality, and fertility is widely documented; see, for example, a recent study based on data from Brazil, Honduras, and Mexico (Horton, S., et al. 1996. Breastfeeding promotion and priority setting. *Health Policy and Planning* 11(2): 156–168.)

2. Sustainability Study

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Background

In 1988, La Leche League International (LLLI) received a U.S. Agency for International Development (USAID) child survival grant to work with La Leche League of Guatemala (LLLG) to implement a community-based mother-to-mother support program in the poor peri-urban areas of Guatemala City. When the USAID grant terminated four years later, LLLG and the communities continued the project, described by Maza et al.[1]

In 1996, BASICS provided LLLI and LLLG with funding and technical support to undertake a study of the reasons for the apparent success and sustainability of the Guatemala program. The study focused on the following questions:

- In what sense has the community-based mother-to-mother support project in the peri-urban areas of Guatemala City been sustained?
- What factors have made sustainability possible?
- Can La Leche League establish norms that systematically promote sustainability of its programs?

Methodology

A two-level approach was used to measure the sustainability of the community-based mother-to-mother support project. The first level measured program coverage—is it accessible to the women in the the community and is it utilized by them? The target population included pregnant women, mothers with children under 24 months, and other women of fertile age. Level I also included the activities of BCs that might facilitate the mother-to-mother support network, as well as the personal characteristics of BCs that might contribute to their effectiveness.

The level I surveys, conducted during April and March 1996, obtained two types of data:

- Household survey of a sample of women living in one community called El Limón within the project area where LLLG has worked for the past seven years.
- A structured interview with as many of the original BCs as could be located.

These household survey data were used to ascertain the coverage of the program (i.e., the proportion of women in El Limón who were in contact with BCs and received services from them). The BC interview data were used to determine the patterns of activity and productivity among the BCs and to identify factors that might enhance the sustainability of the program.

Level II evaluated administrative and financial data from LLLG records, including financial reports, attendance records at support group meetings, and calendars maintained by individual BCs to record the number of individual counseling sessions, home visits, and referrals. There were four interviewers in charge of collecting the information, three of whom had worked previously with LLLG and were familiar with the study community.

After the survey questionnaires were designed and revised, they were field tested in the community of Santa Fé, as well as with the BC coordinators at the monthly refresher workshop in the LLLG office. (One of the interviewers had acted as supervisor to ensure that the questionnaires were complete.) The questionnaires were then modified based on feedback from the interviewers and from the technical personnel of LLLG. Three meetings of the technical personnel of LLLG and the interviewers followed to organize the results. The data from the questionnaires were entered into Epi Info twice by two different persons to validate the consistency of data entries.

Household Survey

El Limón was chosen to survey the target population because it is one of the communities with a large number of reporting BCs (12) working in an easily defined area. Furthermore, this community has a health center (Santa Elena) that is located close to the work area of the BCs and with which the BCs collaborate; in fact, one of the support groups is held there.

El Limón has a population of approximately 12,000 and is divided into 10 sectors. The sectors in turn are divided into 83 blocks and the blocks into lots (dwellings). The number of lots in each block varies a great deal, anywhere from 10 to 35. Besides the 10 sectors, there are various squatter settlements as well, each one with its own name. However, the population of these squatter settlements is unknown and for this reason they were not included in the study, even though the women from these areas participate in the mother-to-mother support network.

Using discussions with the BCs in El Limón as a guideline, a map of the areas covered by their activities was drawn. It was determined that the activities of the BCs were concentrated principally in five of the ten sectors (#2, #6, #7, #8, and #9). The survey covered all the lots in the five selected sectors and then expanded to sectors #4 and #10 in order to obtain a sample of 500 women. The sample size was chosen to ensure that an adequate number of pregnant women and mothers with children under 24 months would be included in the study. Only one woman of fertile age from each lot was included in the sample. First priority was given to mothers with children under 24 months, followed by pregnant women and, last, other women of fertile age. (See Appendix A for a sample questionnaire.)

The interviewers visited 50 blocks out of the total 83. The number of women of fertile age in each block varied a great deal, from 1 to 46. Some blocks had more lots than others. A total of 501 women of fertile age were interviewed; complete data were obtained on 499 of them. As seen in Table 2-1, 46 of the 499 women said they were pregnant; 450 were not pregnant and had at least one child in the house; and 3 said they did

Table 2-1. Distribution of Women in Study Sample by Age of Youngest Child

Age of Youngest Child	Pregnant	Not Pregnant	Does Not Know Whether Pregnant	Total
<6 months	1	60		61
6–23 months	12	109	1	122
24 months and over	20	222	2	244
No children	13	59		72
Total	46	450	3	499

not know whether or not they were pregnant. Information was obtained on the youngest child: 61 were under age 6 months; 122 were between age 6 and 24 months; and 244 were 24 months old and over. Of the estimated population that corresponds to the sectors included in the study, only 3.3% of the mothers had children under 24 months. However, as was expected, pregnant women comprised one-fourth of this percentage.[2]

To reach the target sample of 500 women, the interviewers included 22 women whom they met in the marketplace and at the health center (3 pregnant women, 8 with children under 24 months, and 11 women of fertile age). They lived in sectors #1 (one); #2 (seven); #3 (two); #6 (two); # 7 (four); # 8 (three); # 9 (two); and #10 (one). These women were included in the study because of the similarity of characteristics to the rest of the women in the sample.

Due to the small number of pregnant women in the study, for the most part the data for them and for the mothers of children under 6 months were combined for the purposes of analysis. This seemed appropriate since this population is the program's focus for breastfeeding promotion and for referrals to health services for mothers and children.

Survey of BCs

Since LLLG initiated its project in the peri-urban communities of Guatemala City, 214 BCs have been trained. Of this total, 68 BCs who had been trained through other programs—48 through the Church of Jesus Christ of Latter-day Saints (CLDS) and 20 through the Salvation Army—and 5 who did not work in the communities were excluded from the survey. Out of the remaining 141 BCs who could be included in the study, it was possible to locate only 102 (72%). The rest had moved away from their communities and one had died. The questionnaires were designed to gather demographic and socioeconomic data as well as data on the project activities of reporting and nonreporting BCs. (See Appendix B for a sample of the questionnaire used in interviewing the BCs.)

Study Findings

The household survey shows the demographic and socioeconomic characteristics of the women in the study sample to be homogeneous. The average age of the pregnant women, mothers with children under 6 months, and mothers with children from 6 to 23 months was 25. The average age of the other women of fertile age was 32 (Table 2-2).

Services Received

Nearly 90% of all the women surveyed had a gas stove, installed running water, toilet (flush system), and a home constructed with brick or cement block. Three-fourths of them owned their own homes. The only socioeconomic characteristic that varied was the type of floor in the homes—34% had a floor that can be mopped, 56% had a cement slab, and 10% had a dirt floor (Table 2-3).

Table 2-2. Demographic Characteristics of Women Surveyed by Target Population Group

Characteristic	Pregnant or with Child <6 Months (N = 106)	Not Pregnant, with Child 6–23 Months (N = 110)	Other Women of Fertile Age (N = 283)	Total (N = 499)	
Percentage of women according to age range					
<20 years	26%	20%	16%	19%	
20–24 years	33%	31%	14%	22%	
25–29 years	18%	27%	11%	16%	
30–34 years	15%	11%	15%	14%	
35–39 years	7%	6%	18%	13%	
Over 40	2%	5%	27%	17%	
Total	100%	100%	100%	100%	
Average age in years	24	25	32	29	(497)
Average no. of children	2.2	2.5	2.7	2.6	(497)

Counseling

The data on women in the survey who were in contact with BCs and received services from them in the past three months are shown in Table 2-4. Three-fourths of these women said they had received advice about breastfeeding at some point in their lives. It is perhaps important to note that the majority of these women had received such advice in a health center or at the social security facility, which comes under the category "others."

The fact that the communities do not seem to be familiar with the word *monitora* (breastfeeding counselor) but do know the words volunteer or promoter was a limiting factor in determining the number of women who knew a BC or had had contact with one. Thus, in order to make sure that the women were indeed referring to a BC, the interviewers asked the women to name her and checked the name given against the list of BCs in El Limón. Therefore, the results probably underestimate the true proportion of mothers who had contact with a BC, because the women could have had contact with a BC without remembering her name.

In asking the women if they had heard of "a woman who knows a lot about breastfeeding," 31% answered in the affirmative and, interestingly, the majority (77%) of those identified did turn out to be BCs. It is also interesting that the percentage of women who knew a BC was similar for all three target groups (pregnant woman, mothers with children under 24 months, and women of fertile age), which seems to indicate that the BCs are rather even-handed in promoting breastfeeding to all groups of women and not just to mothers with children under 24 months, as was thought initially. Although there are only 12 BCs in El Limón, one-fourth of the women in the survey sample have had contact with a BC. The importance of training more BCs to increase the coverage of the program seems to be a reasonable assumption based on the above information. In addition, a "ripple effect" was noted among the women surveyed, 65% of whom said they had been counseled by a BC and had in turn given breastfeeding advice to other women.

Table 2-3. Socioeconomic Characteristics of the Women Surveyed

Characteristic	Pregnant or with Child <6 Months	Not Pregnant, with Child 6–23 Months	Other Women of Fertile Age	Total	P-Value
Stove:					<.54
Gas	98 (93%)	102 (94%)	271 (96%)	471 (95%)	
Wood	7 (7%)	7 (6%)	10 (4%)	24 (5%)	
Total	105 (100%)	109 (100%)	281 (100%)	495 (100%)	
Water source:					
Installed running	104 (98%)	106 (96%)	277 (98%)	487 (98%)	<.30
Purchased	0 (0%)	3 (3%)	3 (1%)	6 (1%)	
Other	2 (2%)	1 (1%)	3 (1%)	5 (1%)	
Total	106 (100%)	110 (100%)	283 (100%)	498 (100%)	
Excrement elimination:					
Toilet (flush)	101 (96%)	106 (96%)	278 (98%)	485 (97%)	<.08
Latrine (concrete slab)	4 (4%)	3 (3%)	1 (0.4%)	8 (2%)	
Outdoor	0 (0%)	1 (1%)	4 (1.6%)	5 (1%)	
Total	105 (100%)	110 (100%)	283 (100%)	498 (100%)	
Walls:					
Brick/block	91 (86%)	88 (81%)	258 (92%)	437 (88%)	<.01
Wood/slats	11 (10%)	10 (9%)	14 (5%)	35 (7%)	
Lamina	4 (4%)	9 (8%)	10 (3%)	23 (4.5%)	
Other	0 (0%)	2 (2%)	0 (0%)	2 (0.5%)	
Total	106 (100%)	109 (100%)	282 (100%)	497 (100%)	
Floor:					
Granite or similar	28 (26%)	34 (31%)	109 (39%)	171 (34%)	<.05
Cement slab	62 (59%)	62 (57%)	153 (54%)	277 (56%)	
Dirt	16 (15%)	13 (12%)	20 (7%)	49 (10%)	
Total	106 (100%)	109 (100%)	282 (100%)	497 (100%)	
House:					
Own	61 (58%)	65 (59%)	232 (82%)	358 (72%)	<.0001
Rent	33 (31%)	34 (31%)	37 (13%)	104 (21%)	
Other	12 (11%)	11 (10%)	14 (5%)	37 (7%)	
Total	106 (100%)	110 (100%)	283 (100%)	499 (100%)	

Note: P=probability that observed difference among columns is due to chance.

Referrals

BCs were introduced to child survival interventions as a part of their training so they would be able to refer mothers and children to health services as needed. The survey results show that of all the women who had contact with a BC, nearly two-thirds had been referred to some health service and 90% of them had followed through on the advice (Tables 2-5 and 2-6). This indicates to us that the BCs have a great deal of credibility among the women of their communities. The majority of the referrals were made during individual counseling sessions or home visits (41%).

Table 2-4. Program Coverage: Accessibilty and Outreach

Characteristic	Pregnant or with Child <6 Months	Not Pregnant, with Child 6–23 Months	Other Women of Fertile Age	Total
Has someone spoken to you about breastfeeding?	63/106 (60%)	81/110 (74%)	212/283 (75%)	356/499 (72%)
In less than 3 months	23/63 (36%)	11/81 (14%)	19/209 (9%)	53/353 (15%)
Who?				
NGO	2/63 (3%)	2/81 (2%)	21/212 (10%)	25/356 (7%)
BC	6/63 (9%)	5/81 (6%)	15/212 (7%)	26/356 (7%)
Mother	7/63 (11%)	8/81 (10%)	21/212 (10%)	36/356 (10%)
Others	17/63 (27%)	27/81 (33%)	74/212 (35%)	118/356 (33%)
Health Center	31/63 (49%)	29/81 (48%)	81/212 (38%)	151/356 (42%)
Know someone who knows about breastfeeding?	28/106 (26%)	38/110 (35%)	88/283 (31%)	154/499 (31%)
BCs among those identified	21/26 (81%)	29/38 (77%)	66/87 (76%)	116/152 (77%)
Ever been counseled by a BC?	17/21 (81%)	23/30 (77%)	45/65 (70%)	85/116 (73%)
Know where a BC lives?	20/21 (95%)	27/30 (90%)	60/65 (92%)	107/116 (92%)
Ever looked for a BC for advice?	8/21 (38%)	14/30 (47%)	19/65 (29%)	41/116 (35%)
Ever been visited by a BC?	10/21 (48%)	21/30 (70%)	36/65 (55%)	67/116 (58%)
Ever had contact with a BC?	25/106 (24%)	31/110 (28%)	69/283 (24%)	125/499 (25%)
Ever counseled other women?	16/25 (64%)	24/31 (77%)	41/69 (59%)	81/125 (65%)

Support Groups

Thirty percent of the women surveyed knew of the existence of support groups in their communities (Table 2-7). However, only 37% of these women had ever attended one of these groups. In part this might be due to the fact that to "have heard" that support groups exist (survey question) may not be sufficient motivation to attend them. It is LLLG's experience that support groups grow gradually and the women come to them because they are personally invited by someone they know or by someone who is close to them. It is for this reason that support groups have a limited application for widely promoting breastfeeding, but they are a *very effective* way for women to learn about good breastfeeding practices. Given that the focus of support groups is to help mothers make decisions and take action by offering individual and group support, as well as by providing useful information, the size of each group ought to be limited to allow a certain amount of intimacy between the BC and the participating women.

Of all the women who knew about support groups, the majority had heard of them from a BC (34%) or a friend (16%). It is important to point out that the local health center is also playing an important role in promoting support groups. The number of times that each woman

Table 2-5. Referrals for the Children of Women Who Have Had Contact with a BC

Characteristic	Pregnant or with Child <6 Months	Not Pregnant, with Child 6–23 Months	Other Women of Fertile Age	Total
Referrals	16/25 (64%)	24/31 (77%)	41/69 (59%)	81/125 (65%)
Referrals who went to a health service	13/16 (81%)	22/24 (92%)	38/41 (93%)	73/81 (90%)
How referral was made:				
Individual counseling	4	3	15	22
Support group	3	6	8	17
Home visit	8	15	18	41
Other	1	0	0	1
Total	16	24	41	81
Reason:				
Growth and development	7	12	19	38
ARI	2	1	11	14
Diarrhea	1	7	4	12
Immunization	4	2	6	12
Other	2	2	1	5
Total	16	24	41	8

Table 2-6. Referrals for Women Who Have Had Contact with a BC

Characteristic	Pregnant or with Child <6 Months	Not Pregnant, with Child 6–23 Months	Other Women of Fertile Age	Total
Referrals	18/25 (72%)	15/31 (48%)	33/69 (48%)	69/125 (53%)
Referrals who went to a health service	11/18 (61%)	11/15 (73%)	18/33 (54%)	40/66 (61%)
How referral was made:				
Individual counseling	5	2	7	14
Support group	2	2	7	11
Home visit	10	10	16	36
No answer	1	1	3	5
Total	18	15	33	66
Reason:				
Prenatal care	10	6	8	24
Child spacing	4	1	13	18
Other	4	7	11	22
No answer	0	1	1	2
Total	18	15	33	66

Table 2-7. Surveyed Women's Knowledge of and Access to Support Groups

Characteristic	Pregnant or with Child <6 Months		Not Pregnant with Child 6–23 Months		Other Women of Fertile Age		Total	
Have you heard of the support groups?	28/106	(26%)	33/109	(30%)	92/282	(33%)	153/497	(31%)
Who told you?								
BC	8/28	(29%)	12/ 33	(36%)	32/92	(35%)	52/153	(34%)
A friend	4/28	(14%)	6/ 33	(18%)	14/92	(15%)	52/153	(16%)
Health personnel	9/28	(32%)	6/33	(18%)	6/ 92	(7%)	21/153	(14%)
NGO	1/28	(4%)	2/33	(6%)	12/92	(13%)	15/153	(10%)
Relative	1/28	(4%)	3/33	(9%)	10/ 92	(11%)	14/153	(9%)
Neighbor	1/28	(4%)	0/33	(0%)	7/92	(8%)	8/153	(5%)
Midwife	0/28	(0%)	1/33	(3%)	1/ 92	(1%)	1/153	(1%)
Other	5/28	(18%)	3/33	(9%)	10/92	(11%)	18/153	(15%)
Have you attended a support group?								
Ever	8/106	(7%)	9/109	(8%)	39/282	(14%)	56/497	(11%)
In last 3 months	2/8	(25%)	1/9	(11%)	2/39	(5%)	5/56	(9%)
Average number of times (last 12 months)	4 (N=8, sd=4.3)		3 (N=9, sd=3.7)		7 (N=39, sd=9.6)		6 (N=56, sd=8.4)	

Note: sd=standard deviation

attended a support group varied greatly. In the study, the average number of support group attendance was six times in the 12 months preceding the survey. The data seem to indicate that socioeconomic characteristics or contact with BCs are not determinants of attendance in support groups (Table 2-8).

There appears to be a definite correlation between program coverage and the number of BCs living in a given sector (Table 2-9). For instance, the percentages for contact with BCs as well as attendance at support groups are consistently higher for women who live in sector #9 than for those from other sectors, because that is where various active BCs live in El Limón. Transportation may be a factor in a BC's ability to contact women living at some distance from her home.

Services Provided by BCs

The LLLG records classify BCs as active or inactive. The active status is determined by the fact that they lead at least one support group a year and hand in to LLLG the completed support group form. BCs are also classified as active if they hand in at least three times a year their monthly calendar pages showing individual counseling sessions, referrals, and home visits. However, this study revealed that the majority (91%) of the BCs considered "inactive" in the LLLG records are still promoting breastfeeding through individual counseling sessions, referrals, and home visits, although they are not running support groups. It was therefore decided to change the classifications to "reporting" and "nonreporting" for greater accuracy in representing those who are working but are not reporting their work to LLLG.

Table 2-8. Correlation between Socioeconomic Characteristics of Surveyed Women and Their Access to Support Groups and BCs

Characteristic	Have Heard of and Attended a Support Group		P-Value	Have Had Contact with a BC		P-Value
	Yes	No		Yes	No	
	56/153=37%	97/153=63%		126/500=25%	374/500=75%	
House:						
Own	75%	74%	NS	75%	70%	NS
Rent	14%	19%		16%	23%	
Other	11%	7%		9%	7%	
Stove:						
Gas	88%	98%	<.01	94%	96%	NS
Wood	12%	2%		6%	4%	
Water source:						
Installed/running	98%	98%	NS	96%	98%	<.04
Other	2%	2%		4%	2%	
Excrement elimination:						
Toilet (flush)	96%	98%	NS	96%	98%	NS
Latrine (cement slab)	2%	0%		2%	1%	
Outdoor	2%	2%		2%	1%	
Walls:						
Brick/cement block	80%	92%	NS	86%	89%	NS
Wood/slats	13%	4%		9%	6%	
Lamina	7%	3%		5%	4%	
Other	0%	2%		0%	1%	
Floor:						
Granite or similar	18%	6%	<.06	13%	9%	NS
Cement slab	55%	59%		57%	55%	
Dirt	27%	35%		30%	36%	

Notes: P=probability that observed difference among columns is due to chance. NS=statistically not significant.

Characteristics

Table 2-10 shows the demographic characteristics of the 102 BCs interviewed for the study. The average age of the reporting and nonreporting BCs was found to be about the same (43 years). There is little difference either in the average number of children or in the level of literacy between the two groups. The nonreporting BCs are somewhat more educated than the reporting ones (30% vs. 24% have completed primary school and have a slight edge over the reporting BCs in having some secondary and postsecondary education), which perhaps better qualifies them for paid work outside their communities. This factor may also contribute to their nonreporting status because their time is likely devoted to other pursuits.

Table 2-9. Program Coverage by Sector

Characteristic	Sectors						
	2	3	6	7	8	9	10
Knows a woman who is informative about breastfeeding	34%	31%	15%	25%	35%	56%	15%
Has heard of a support group	73%	76%	72%	67%	72%	61%	59%
Has attended a support group	68%	57%	67%	67%	65%	53%	54%
Has had contact with a BC	30%	21%	7%	23%	21%	49%	19%
Number of women interviewed	127	29	54	131	80	48	27

Table 2-10. Demographic Characteristics of Surveyed BCs

Characteristic	Reporting (N=45)	Nonreporting (N=57)	All BCs (N=102)	P-Value
Average age	45	41	43	NS
Average no. of children	4.4	3.9	4.1	NS
Proportion according to age group:				
<.31				
<20	1 (2%)	0	1 (1%)	
20–24	0 (0%)	5 (9%)	5 (5%)	
25–29	3 (7%)	6 (11%)	9 (9%)	
30–34	6 (13%)	6 (11%)	12 (12%)	
35–39	11 (24%)	13 (23%)	24 (24%)	
40 and over	24 (53%)	27 (47%)	51 (50%)	
Total	45 (100%)	57 (100%)	102 (100%)	
Schooling:				NS
None	7 (16%)	7 (12%)	14 (13%)	
Primary incomplete	16 (36%)	11 (19%)	27 (27%)	
Primary complete	11 (24%)	17 (30%)	28 (28%)	
Secondary incomplete	5 (11%)	7 (12%)	12 (11%)	
Secondary complete	5 (11%)	3 (5%)	8 (8%)	
Other	1 (2%)	12 (21%)	13 (13%)	
Total	45 (100%)	57 (100%)	102 (100%)	
Knows how to read and write	38 (84%)	52 (91%)	90 (88%)	NS

Notes: P=probability that observed difference among columns is due to chance. NS=statistically not significant.

In a demographic comparison with the women of El Limón, the BCs generally are older and possibly have older children and, therefore, have more time for other activities. On the socioeconomic scale, it seems that on the whole fewer of them have indoor running water, flush toilets, and cement block walls (Table 2-11).

Table 2-11. Socioeconomic Characteristics of Surveyed BCs

Characteristic	Reporting (N=45)		Nonreporting (N=57)		All BCs (N=102)		P-Value
Stove:							
Gas	40	(89%)	53	(93%)	93	(91%)	<.46
Wood	5	(11%)	4	(7%)	9	(9%)	
Water source:							
Installed running	37	(84%)	47	(83%)	84	(83%)	<.83
Other	7	(16%)	10	(17%)	17	(17%)	
Excrement elimination:							
Toilet (flush)	32	(74%)	44	(77%)	76	(76%)	<.74
Latrine (cement slab)	11	(26%)	13	(23%)	24	(24%)	
Walls:							
Brick/block	29	(64%)	41	(72%)	70	(69%)	<.43
Wood/slats	12	(27%)	14	(25%)	26	(26%)	
Other	4	(9%)	2	(3%)	6	(6%)	
Floor:							
Granite	10	(22%)	17	(30%)	27	(27%)	<.40
Cement slab	24	(53%)	32	(56%)	56	(55%)	
Dirt & other	11	(24%)	8	(14%)	19	(19%)	
House:							
Own	36	(80%)	46	(81%)	82	(80%)	<.08
Rent	2	(4%)	8	(14%)	10	(10%)	
Other	7	(16%)	3	(5%)	10	(10%)	

Note: P=probability that observed difference among columns is due to chance.

Activities

Both reporting and nonreporting BCs show a high level of activity during the three months (January–March 1996) preceding the survey (Table 2-12); 84% of both groups had individual counseling sessions in that period. However, the average number of individual counseling sessions and referrals made by the reporting BCs was double that of the nonreporting ones. The average time given to their program activities is a little higher for the reporting BCs, possibly because some of them lead support groups.

Table 2-13 shows that the BCs are very active outside of their work with the LLLG program—51% do paid work and 69% do other volunteer work. These figures do not include BCs who are residents of La Esperanza, many of whom work for UPAVIM,[3] an NGO formed by this community. A majority (61%) of the 23 reporting BCs who also do paid work do so for this NGO, while only 39% are employed elsewhere. This is an important fact because BCs who work at UPAVIM also contribute a certain amount of volunteer time to leading support groups as part of their LLLG program activities.

Table 2-12. Program Activities of Surveyed BCs

Characteristic	Reporting (N=45)	Nonreporting (N=57)	All BCs (N=102)	P-Value
Last individual counseling in:				NS
3 months or less	93%	77%	84%	
Over 3 months	4%	16%	11%	
None	2%	7%	5%	
Average no. of individual counselings for BCs who counseled during Jan–Mar 1996	90 (45)	54 (57)	72 (102)	
Last home visit in:				
3 months or less	84%	37%	58%	
Over 3 months	9%	18%	14%	
None	7%	46%	28%	
Average no. of home visits of BCs who made visits during Jan–Mar 1996	29 (N=38)	37 (N=21)	32 (N=59)	
Last referral in:				
3 months or less	78%	65%	71%	
Over 3 months	9%	5%	7%	
None	13%	30%	23%	
Average no. of referrals by BCs who referred during Jan–Mar 1996	26 (N=34)	13 (N=35)	19 (N=69)	NS
Last support group in:				
1 year or less	76%	12%	40%	
Over 1 year	24%	88%	60%	
Hands in support group form	94%	0%	78%	
Average time (hours) given to activities/month*	23 (N=35, sd=30)	13 (N=45, sd=18)	18 (N=80, sd=24)	NS

Notes: N=number of respondents where different from totals interviewed; NS=statistically not significant; sd=standard deviation

* Excludes four reporting BCs who reported spending more than 100 hours per month.

According to the data shown in Table 2-14, more nonreporting BCs do paid work than the reporting ones, and the difference is statistically significant.

Before the termination of the grant in 1992, all the BCs met to elect a coordinator and subcoordinator for each community represented at the meeting to act as their representives and maintain liaison with LLLG. The coordinators and subcoordinators attend the monthly mini-workshops in the LLLG office and bring the calendar sheets and the mother-to-mother support group forms of their fellow BCs in each community. They are also in charge of reporting other activities in the communities. Table 2-15 shows the activities of the coordinators (the activities of the subcoordinators are not included here). The majority of the coordinators visit their fellow BCs at least once a month and participate in the monthly mini-workshops.

Table 2-13. Types of Paid and Volunteer Work of BCs

Characteristic	Reporting BCs	Nonreporting BCs	All BCs	P-Value
Paid work	23/45 (51%)	29/57 (51%)	52/102 (51%)	
Type of paid work:				<.001
UPAVIM	14 (61%)	0 (0%)	14 (26%)	
Health	1 (4%)	4 (14%)	5 (10%)	
Midwife	1 (4%)	1 (3%)	2 (4%)	
Other	7 (30%)	24 (83%)	31 (60%)	
Total	23	29	52	
Other volunteer work	38/45 (84%)	32/57 (56%)	70/102 (69%)	
Type of volunteer work:				<.12
UPAVIM	10 (26%)	3 (9%)	19 (27%)	
Health services	8 (21%)	11 (34%)	15 (21%)	
Midwifery	10 (26%)	5 (16%)	13 (19%)	
Other	10 (26%)	13 (41%)	23 (33%)	
Total	38	32	70	

Note: P=probability that observed difference between reporting and nonreporting BCs is due to chance.

Table 2-14. Paid Work of BCs Excluding Those Who Work for UPAVIM

	Reporting BCs	Nonreporting BCs	All BCs
Do you do paid work?			
Yes	9 (29%)	29 (51%)	38
No	22 (71%)	28 (49%)	50
Total	31 (100%)	57 (100%)	88
		p<.05	

Table 2-15. Activities of the Coordinators

Activity	Percentage of Coordinators	
Visits BCs	4/5	(80%)
Frequency of visits:		
Once a month	3/4	(75%)
Twice or more a month	1/4	(25%)
Participates in monthly mini-workshops	5/6	(83%)
Frequency of participation during January–March 1996:		
3 mini-workshops	4/5	(80%)
2 mini-workshops	0/5	(0%)
1 mini-workshop	1/5	(20%)

Sustainability

The data on factors that motivate the BCs to continue their project activities and contribute to the sustainability of the project were analyzed by community for the 10 communities included in the study (Table 2-16). We found that a majority of the reporting BCs who lead support groups and feel supported by their coordinators as well as by LLLG live in the communities of El Limón, Santa Fé, La Esperanza, Tierra Nueva, and Chinautla. The differences among the communities are significant. It is clear that the coordinators who are elected by the community enjoy greater credibility and cooperation in the community and, therefore, are better able to strengthen the bond between BCs and LLLG. In a community where the coordinator has quit or stopped functioning for some reason, the BCs discontinue support groups and stop reporting activities to LLLG.

Table 2-16. Some Characteristics of BCs by Community

Community	Reporting BCs as Fraction of All BCS	Had Support Group <1 Year	Receives Visits from Coordinator	Feels Support from Coordinator	Feels Support from LLLG
El Limón	12/20	13/20	11/16	11/15	15/17
Santa Fé	5/12	4/12	3/11	6/11	9/12
La Esperanza	16/27	16/27	5/25	17/26	23/27
Forestal	0/5	0/5	NA	NA	1/5
Plaza de Toros	0/6	2/6	NA	NA	0/6
Guadalupano	0/9	0/9	NA	NA	2/9
Chinautla	9/11	4/11	3/10	4/10	9/11
Sectors 5 & 8	1/9	0/9	NA	NA	0/8
Tierra Nueva	2/3	2/3	1/2	1/2	2/3
Total	45/102	41/102	23/90	40/89	61/98
P-value	<.000	<.001	<.03*	<.51*	<.000

Notes: NA=Not applicable because these communities do not have coordinators. P=probability that observed difference among rows is due to chance.
* Excludes communities that do not have coordinators.

Structure, Supervision, and Support

Organizational Structure of LLLI

LLLI was founded in 1956 and incorporated in 1958 as a 501(c)3 international private voluntary organization (PVO). Its headquarters is located in Schaumburg, Illinois, U.S.A. LLLI is governed by an international board of directors, whose 16 members come from seven geographic zones, namely, Africa/Middle East, Latin America, Canada, Europe, South Pacific/Asia, Eastern United States, and Western United States. The board establishes policy, governs the business and administrative affairs of the corporation, and hires the executive director.

The volunteers (called LLL leaders) in the field receive support from the headquarters through:

- The Leader Department and the Leader Accreditation Department—each composed of administrative levels that begin in the community with an LLL Group and continue through the area (e.g., at the state level in the U.S.A. or at the country level in Latin America such as LLLG); the region, comprised of various areas grouped according to geography and language, such as the Region of Latin American and the Caribbean Spanish-speaking countries; the division, comprised of various regions within three separate divisions—international, eastern U.S.A., and western U.S.A.

- The international headquarters in Schaumburg, Illinois, which functions as the backstop for the organization as a whole. The services offered by the headquarters include the Center for Breastfeeding Information, the Publications Department, the Public Relations Department, and the International Action and Development Department. The database of research and studies at the Center for Breastfeeding Information, for instance, serves as the basis for the accuracy of information in the publications produced by LLLI.

The headquarters also facilitates the organization's registered status with USAID, its consultative status with UNICEF, and its formal working relations with WHO.

The child survival project was LLLI's first attempt to work with and through La Leche Leagues in the field to implement a mother-to-mother support model of breastfeeding promotion among low-income populations. LLLI was successful in raising $75,120 in matching funds (25% of a USAID child survival grant), which enabled both Guatemala and Honduras to establish offices and staff them. With the ending of the child survival grant in 1993, the LLLI board of directors established an International Action and Development Department at the headquarters, which has since had an ongoing working relationship with LLLG. This department coordinated the presentation of an LLLG study at a worldwide child survival conference in India in 1994, as well as planned a Central American focus group meeting in Honduras in 1995 to discuss mother-to-mother support programs. Two BCs and one LLLG leader attended the meeting. In addition, the department has secured funding for a joint LLLI/LLLG project to produce a mother-to-mother support comic book series and coordinated the sustainability study presented in this paper.

Organizational Structure of LLLG

LLLG obtained its legal status in 1991 and established its first board of directors. Initially the board of directors was made up entirely of La Leche League leaders; it now also includes members who are not in the league. As stated elsewhere, the funding of the child survival project ended September 30, 1992, whereupon LLLI and LLLG received a five-month "no cost extension" until February 1993 in order to expend remaining grant monies. In March 1993, the board of directors decided to continue the project and retained seven members of the LLLG staff at reduced salaries: an administrator, a technical coordinator, a BC coordinator, three field personnel, and a secretary. This arrangement remained in place until December 1993.

During the first three months of 1994, the board was in charge of the day-to-day management of LLLG. At the end of March 1994, the board invited curricula vitae from LLLG leaders interested in positions with the project. Subsequently, a director and a technical coordinator were hired half time from among the applicants. They have continued to work with the BCs, provide technical assistance, manage the LLLG office, and do fundraising for the project. The director reports to the board and attends board meetings, but he is not a voting member. The office secretary is hired half time as well. From April 1994 through September 1996, LLLG has maintained this permanent staff and has contracted individuals for specific jobs.

LLLG is a designated area within the structure of LLLI, with an Area Coordinator of Leaders and a Coordinator of Leader Aspirants. These two coordinators report to the regional administrators of Latin America, who in turn report to the director of the International Division of LLLI. Each active leader pays minimal annual dues of US $6 or US $24, the latter covering the cost of two magazines in English published by LLLI (*New Beginnings* and *Leaven*). The board of directors has stipulated an indirect cost charge of 10% and 6% for LLLG and LLLI, respectively, on all proposals for training and technical assistance from national and international NGOs. The 6% indirect cost paid to LLLI is divided into 4% for the central office and 2% for the international division. The same stipulation applies to consultancies for leaders who are employed by LLLG (10% of their honorariums go to LLLG and 6% to LLLI).

Presently, LLLG has seven active leaders and ten leader aspirants. All leaders are responsible for co-leading a support group on a volunteer basis once a month in the urban areas of Guatemala City. There is a monthly evaluation session for all leaders and aspirants.

The regulations of the LLLG board of directors stipulate that no LLLG employee can serve on the board to avoid possible conflict of interest. The director and the technical coordinator work 40% time in the community-based mother-to-mother support project: four days a month giving refresher courses to BCs in four peri-urban communities; one day a month facilitating a mini-workshop in the LLLG office assisted by coordinators and subcoordinators of seven peri-urban communities; one day a month in training; and one day a month in another activity related to peri-urban community work (Table 2-17). In 1995 and 1996, a BC from Santa Fé was nominated and elected to the board of directors.

The coordinators and subcoordinators are elected for a period of six months or a year and can be reelected by the BCs of their communities. From among this group of coordinators, an overall coordinator and subcoordinator are elected for a period of one year. Approximately 70% to 80% of the coordinators attend monthly mini-workshops held at the LLLG office, where they represent the other BCs from their communities. This system of coordination is designed to promote cohesion among the BCs by:

- Engendering self-sufficiency among the BCs in their communities in order to keep their mother-to-mother support groups active in supporting, protecting, and promoting breastfeeding.

Table 2-17. Project Personnel in Three Periods

Activity	January–December 1993	January–March 1994	April 1994–June 1996
Staffing	Administrator 2 coordinators 3 field personnel 1 secretary Total = 7 at 50% time	Board of directors Personnel hired for specific jobs	Director (40%) Technical coordinator (40% time) Secretary (50% time) Personnel hired for specific jobs
Community work	Project areas: El Carmen Chinautla Esperanza Guadalupano El Limón Santa Fé Tierra Nueva Sector 5 Sector 8 15 de agosto 9 Communities from CLDS Roosevelt Hospital	Project areas: El Carmen Chinautla Esperanza Guadalupano El Limón Santa Fé Tierra Nueva Sector 5 9 Communities from CLDS Roosevelt Hospital	Project areas: El Carmen Chinautla Esperanza El Limón Santa Fé Tierra Nueva Sector 5
Time dedicated to community work	7 half-time personnel	Personnel hired for specific jobs in the community	2 (4 days, communities; 2 days, training & technical assistance; 1 day other activities = 16 days/month = 40% time)

- Maintaining intercommunity relationship with and among the BC coordinators.
- Maintaining a program of continuing education that can be replicated in each program community.
- Recognizing, stimulating, and reinforcing the work of the BCs in each program community.

The responsibilities of the general coordinator and subcoordinator are to:

- Schedule support group meetings for each community.
- Receive reports of the work accomplished in the past month in the form of calendar sheets and support group forms with individual counseling and home visits recorded (home visits began to be recorded in 1995).
- Designate dates for refresher courses in each community.

Table 2-18 presents an overview and comparison of the activities of BCs and coordinators during grant period from 1989 to 1992 and the postgrant period from 1993 to 1996. A popular activity added in the postgrant period occurs during the World Breastfeeding Week, when BCs plan and participate in walks with women and children carrying cloth banners, accompanied by school bands and floats to promote the practice of breastfeeding.

Table 2-18. BC and Coordinator Activities in Two Periods

Activity	Child Survival Project 1989–1992	Postgrant Period 1993–1996
Volunteer work:		
BCs	2 hours/week	2 hours/week
Coordinators	3 hours/week	3 hours/week
Types of incentives	Framed diploma Identification carnet Annual workshop Snacks and raffles in refresher courses Christmas party (donation of clothes and other products)	Annual workshop Snacks and raffles in refresher courses Christmas party (donation of clothes and other products) Monthly workshops for coordinators with raffles Mental health course at mini-workshops Course on counseling skills for coordinators Breastfeeding walks in communities during World BF week with donated products
Reimbursement of expenses	Travel to annual mini-workshops, and Christmas party	Travel to annual workshop, mini-workshops, and Christmas party

Organizational Support for BCs

LLLG continued to support the BCs in the postgrant period with two staff persons spending 40% time working with the communities. The BCs themselves reported that the major reasons they have continued working on breastfeeding activities are their own motivation and spirit of service, their mutually supportive relationship with the personnel of LLLG, and their desire to learn more and to share their knowledge with other women in their communities. Survey results related to these factors and other qualitative information are presented in Tables 2-19 through 2-23.

Table 2-19. Factors Motivating Reporting BCs to Continue Their Project Activities

Motivating Factor	Number of Reporting BCs	
Being useful to the community and other persons	18	(40%)
Seeing that baby bottle is no longer used (seeing results)	6	(13%)
The needs of people, especially unprotected children	2	(4%)
Like the work	3	(7%)
Other	16	(36%)
Total	45	(100%)

Table 2-21 presents useful qualitative data about factors that may play a significant role in encouraging and sustaining BCs in their community activities. It is interesting to note that there is a significant difference in responses to all the questions between the reporting and nonreporting BCs. It appears that those BCs who feel more support from LLLG and from their coordinators maintain a higher level of activity; however, it may be that because they report their activities, supportive feedback from their coordinators and LLLG is more likely. Visits from the coordinators seem to be crucial motivators as do monthly refresher courses at LLLG. An invitation from a BC in the community or someone they know and trust appears to have been effective in persuading these women to train as BCs.

Table 2-20. Factors That May Influence BCs' Level of Activity

Factor	Reporting BCs		Nonreporting BCs		P-Value
Feel support from LLLG	43/44	(98%)	15/26	(58%)	<.000
Feel support from coordinator	28/38	(74%)	11/26	(42%)	<.01
Receive visits from the coordinator	18/39	(46%)	5/25	(20%)	<.03
Know there are monthly meetings with other BCs	37/44	(84%)	14/26	(54%)	<.01
Have attended meetings of BCs	23/37	(62%)	2/15	(13%)	<.001
Were invited to the training by:					<.01
NGO in the community	4/45	(9%)	8/57	(14%)	
Health Center	6/45	(13%)	9/57	(15%)	
BC	10/45	(22%)	1/57	(2%)	
Someone from the community	7/45	(16%)	6/57	(11%)	
Someone outside the community	0/45	(0%)	6/57	(11%)	
LLLG	18/45	(40%)	27/57	(47%)	

Notes: P=probability that observed difference between columns is due to chance.

Table 2-21. Reasons Given by the Nonreporting BCs for Not Continuing Their Support Groups

Reason	Frequency of Response
Other work	25 (43%)
Small children	5 (8%)
Lost contact with the group of BCs or LLLG	4 (7%)
Illness	5 (8%)
Lack of time or involvement in other activities	7 (12%)
Other	11 (19%)
Total sample	57 (100%)
Nonreporting BCs who continue to promote breastfeeding	52 (91%)

Table 2-22. What BCs Have Liked Most about Their Work

Indicator	Reporting BCs	Nonreporting BCs	All BCs
Orient, teach, share advice	25 (56%)	39 (68%)	64 (63%)
Learn, receive courses	12 (27%)	6 (11%)	18 (18%)
Other	8 (18%)	12 (21%)	20 (20%)
Total	45 (100%)	57 (100%)	102 (100%)
	p = <.1		

Note: P=probability that observed difference among columns is due to chance.

Table 2-23. What BCs Have Liked Least about Their Work

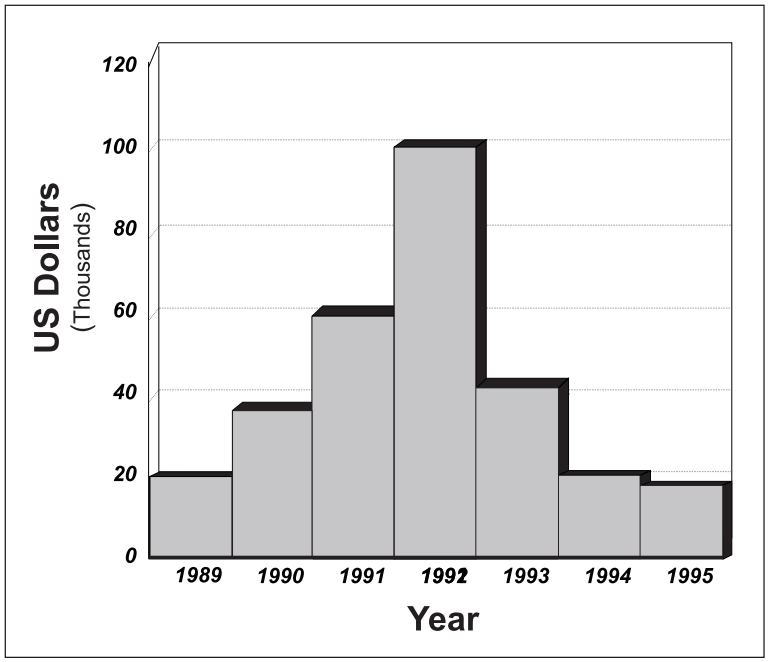
Reason	Reporting BCs	Nonreporting BCs	Total
Everything is fine	18 (40%)	16 (28%)	34 (33%)
No time for meetings	7 (15%)	11 (19%)	18 (18%)
Their advice is not followed	1 (2%)	7 (12%)	8 (8%)
Other	19 (42%)	23 (40%)	42 (41%)
Total	45 (100%)	57 (99%)	102 (100%)
	p = <.2		

Note: P=probability that observed difference among columns is due to chance.

Budget

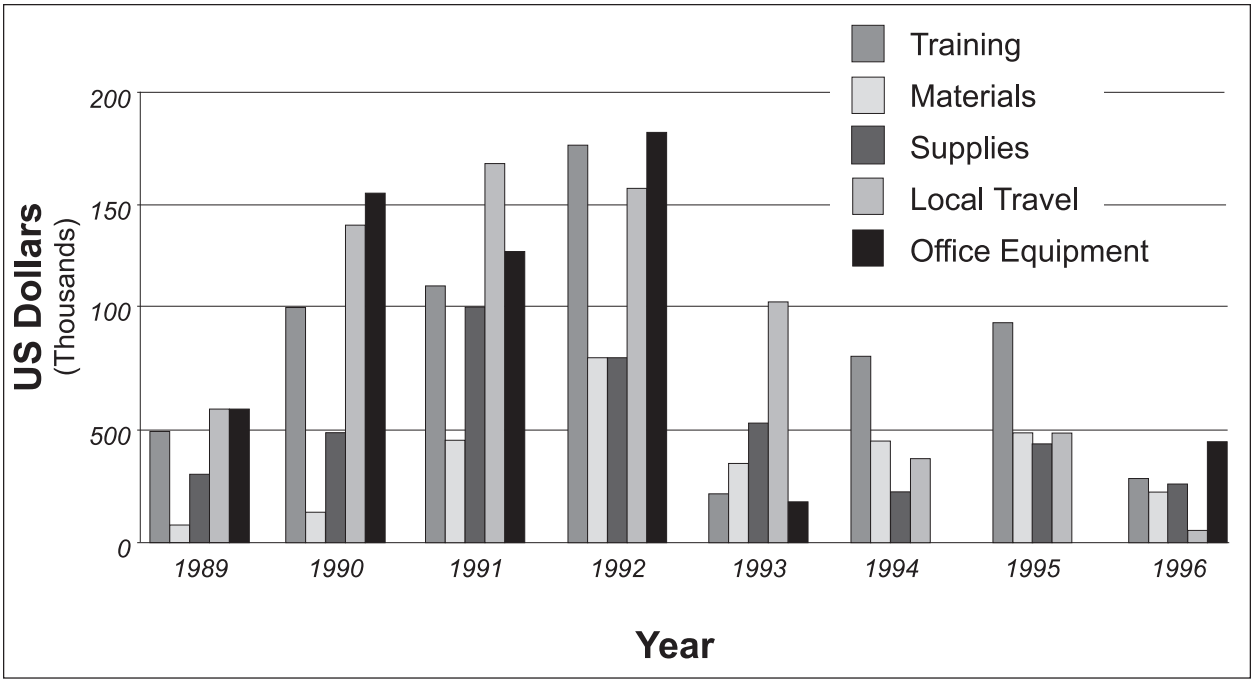
Since the end of the Child Survival Project grant in 1992, LLLG's budget has been cut drastically. There has been a 40% reduction in the project budget since that time (US $189,983 vs. US $74,447). Appendix C shows the expenditures in dollars and quetzales from October 1988 to June 1996. LLLG has been getting some assistance from various sources. Wellstart International and the

Figure 1.
Total Income: October 1989–June 1995



Institute for Reproductive Health at Georgetown University have financed two workshops and a case study. LLLI has also financed a workshop for its leaders in Latin America. The project itself has generated some income by providing technical assistance to some NGOs such as UPAVIM, Center for Integrated Studies in Community Development (CEIDEC), and Friends of the Americas as well as to some private sector institutions—CEMACO (a chain of department stores), a private hospital, and the Church of Jesus Christ of Latter-day Saints. LLLG needs to focus on exploring all avenues for income generation in both the public and private sectors, e.g., promoting and disseminating its banners and training manuals. The summary of income is presented in Appendix D (see also Figure 1).

Figure 2.
Expenses for Training and Overhead, October 1988–June 1996



Appendix E presents major categories of expenditures for the development and maintenance of the Child Survival Project and the subsequent community-based mother-to-mother support project. (The expenses for communications, services, international travel, per diem, personnel training, postage, consultancy, evaluation, maintenance, legal status, kitchen supplies, and strategic planning are included under "Other").

The funds invested in training (refresher courses, mini-workshops, and the annual workshops for BCs), materials, office supplies, local travel, and office equipment are presented in Figure 2. Figures 3 and 4 show expenses for the development of materials and personnel from 1989 through June 1996. The expenses for 1992 exceeded those in the other years in almost every category, the only exception being the development of materials. In 1991, promotional banners were developed and the first *Manual for Breastfeeding Counselors* was designed and produced; a second edition was printed in 1994.

It is important to point out that budget allocation for continuing education of BCs and their activities was a priority in 1994 and 1995. The annual workshop for all BCs was held in August 1996. Staffing costs continue to be high. Although the overall staffing budget was drastically reduced (36%) in the postgrant period, this was achieved by reducing the number of personnel rather than salaries. Also, it must be pointed out that during the final year of the child survival project grant (1992), a director and two coordinators were hired to work 90% time (giving 10% of their time

Figure 3.
Expenses for Development of Materials, October 1989–June 1996

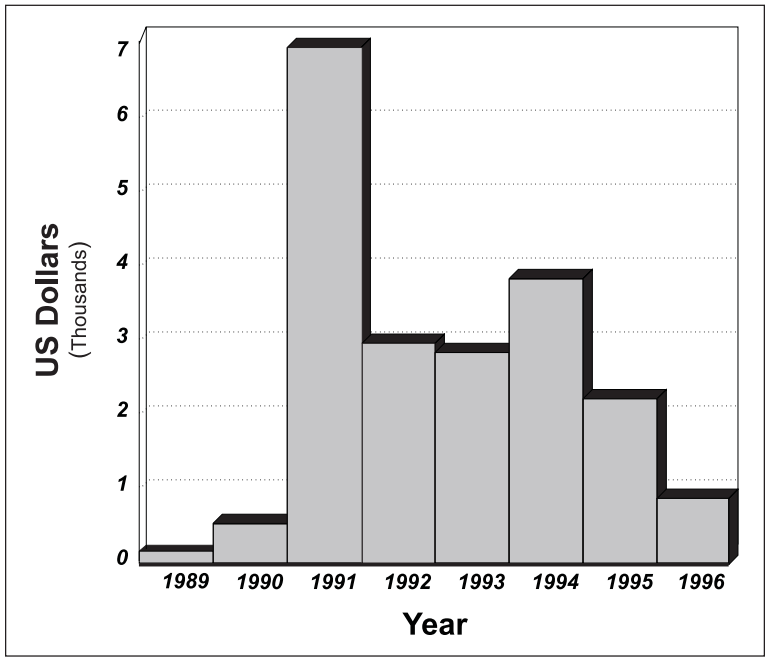
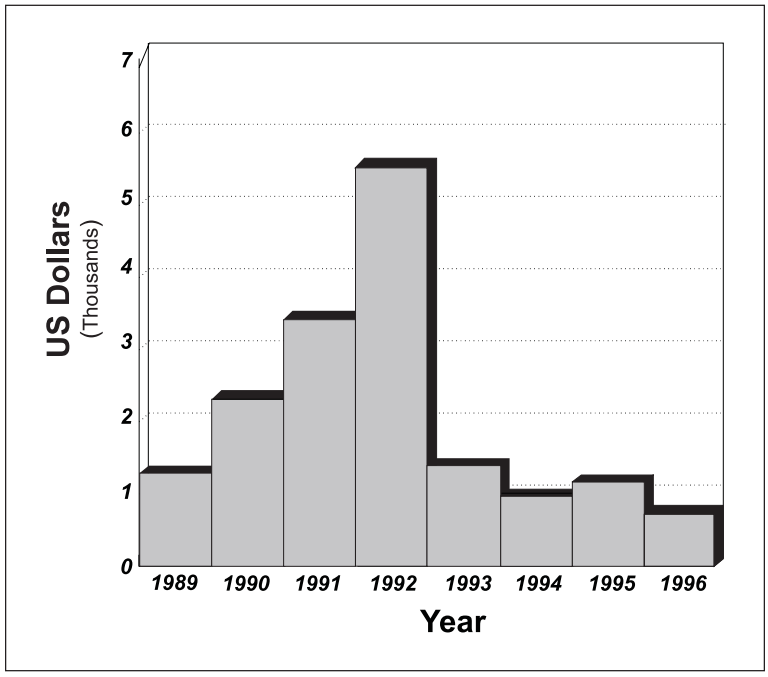


Figure 4.
Personnel Expenses, October 1988–June 1996



in-kind); their time was reduced to 50% in March 1994. It would thus be fair to say that more funds have been expended on personnel than on any other category in the postgrant period. The board of directors of LLLG has a strong commitment to continuing the excellent work being done by the project. The challenge lies in far-sighted planning and in obtaining necessary funding to sustain the project and make it grow.

Additional Information

Although only 45 BCs of the 102 surveyed are active as defined by their reporting status, the work they do in their communities is very impressive. Appendix F shows a sample form for LLLG's System of Community Information on Breastfeeding (the information is collected by the coordinators from the BCs in their communities). The most time- and labor-intensive activity of the reporting BCs revolves around running their support groups. In analyzing the data that appear in Appendix F, it was noted that the total number of women who attended support groups in 1995 was almost 1,000 more than that for 1994, even though there were only half as many groups. A careful look at the data disclosed that the BCs were calling sessions attended by 60 or more women "breastfeeding talks," instead of calling these sessions support groups. So "breastfeeding talks" were added as a new category of volunteer work in June 1996. Each gathering that has more than 20 participants is now classified as a "breastfeeding talk" and not a support group. For this reason the numbers for 1995 and the first six months of 1996 appear very high. Appendix F also shows individual counseling, home visits, and referrals to the health center carried out by the reporting BCs and recorded from the forms they bring to the LLLG office.

At their annual workshop on August 30, 1996, the participating BCs used a designated form to indicate why in their opinion "mothers don't continue to attend support groups" (the BCs who had not run support groups abstained from answering). The list of reasons noted by the BCs was mentioned in the evaluation conducted by DataPro, South America, in 1991: "The La Leche League in Guatemala: An Evaluation of LLLG Activities." The answers from 43 of the attending BCs are presented below in order of frequency (the number of times a reason was given appears in parentheses).

- She is pressured by her family or other persons not to breastfeed. (33)
- She returned to work and cannot attend meetings. (28)
- She has family members who support her and provide her with breastfeeding information. (25)
- She is not convinced about breastfeeding. (23)
- She hasn't come to several meetings and doesn't realize that she can come again whenever she is able and wishes to return. (22)
- The meetings are not at a convenient location or time. (21)
- She has no time to go to a support group. (20)
- She lives far away and is not easily able to come to the group. (20)

- There is no felt need for breastfeeding information. The women believe they know all about breastfeeding. (20)
- Mothers have many obligations in their homes. (19)
- Mothers have no money for bus fares. (18)
- One or two meetings were sufficient for the pregnant woman or the woman who breastfeeds to have the information she needed. (14)
- She missed several meetings and wants to return, but does not know how to contact a BC. (10)

It is useful to know that the most frequently stated reason why the mothers do not continue attending support groups was because of the pressure from family and people around them *not* to breastfeed; perhaps this barrier can be addressed in mini-workshops and refresher training for BCs. The second most frequent reason given was that the mother returned to work and was not able to attend the meetings. The third was similar but in a positive sense, namely, there are family members who support the mother and give her information about breastfeeding; hence, the mother does not need the support group.

Dissemination of the Study

A workshop was held for LLLG board members, LLLG leaders, BCs, and the interviewers to discuss the results of the study and to obtain feedback. The results of the study were also shared at the III Regional Workshop of LLL Latin America held in Asunción, Paraguay, August 4–10, 1996. This workshop on "Exploring Successful Methodologies of Breastfeeding Support Systems" was attended by La Leche League representatives from 12 Latin American countries, LLLI, and representatives from UNICEF headquarters in New York and its regional offices in Paraguay and Bolivia. The ministries of health from Paraguay, Brazil, and Venezuela and CEPREN (Centro de Promocion y Estudios en Nutricion, Peru) and AMAMANTA (a mother-to-mother support program in Venezuela) also participated.

On August 30, 1996, the annual workshop for BCs was held; 53 BCs attended. Before presenting the results of the surveys, the BCs were asked, in work groups, to define what for them was an active and an inactive BC. Surprisingly, all the work groups came up with the same definition for an inactive breastfeeding counselor, namely, one who *has received information but has not shared her knowledge with the women in her community.* None of the BCs in attendance at the annual workshop considered herself inactive (as LLLG erroneously had called the nonreporting BCs). This fact reflects the reality on the ground in the communities, namely, that the BCs are sharing their knowledge and experiences with other women, although many have lost contact with LLLG. During this workshop, the importance of reporting was stressed, and refresher training on how to fill the reporting forms was given. The BCs seemed to be greatly pleased when the results of the study were announced. LLLG believes this sharing of information was a very special incentive for reporting BCs to continue in their work, as well as for many of the nonreporting BCs to return to the network of the mother-to-mother support project.

Conclusions

Upon examining the results of the study, it is clear that LLLG's mother-to-mother support project has succeeded in sustaining nearly the same level of service for more than three years since the grant ended, on a greatly reduced budget ($20,000 per year vs. nearly $50,000 per year). In light of the questions posed by this study, it can be concluded that:

- The reporting BCs continue to offer their services in the communities and to enthusiastically participate in LLLG activities, while the nonreporting BCs are maintaining a high level (90%) of activity through individual counseling.
- The sustainability of the project is related to the personal motivation of the BCs as much as to the personnel of LLLG and to the mutual support and affection that exist between the two groups.
- The socioeconomic and demographic factors do not appear to influence program coverage.

Lessons Learned

A number of lessons can be drawn from the LLLG experience in implementing the community-based mother-to-mother support project in peri-urban areas that may be valuable to other organizations engaged in similar programs:

Community needs. The prominent perceived need in peri-urban communities is physical and economic survival, not health. This perception must be addressed in any program that targets this population.

Establishing a peri-urban project. Community involvement is crucial to the success of any development project. It is the experience of LLLG that all potential candidates for breastfeeding counselors must be recognized and respected women in their communities.

Networking and collaboration. Networking and collaboration with governmental and nongovernmental organizations is an essential link in any community-based mother-to-mother support project. Networking and collaboration add to the strength of support groups, providing a system of two-way referrals and facilitating shared training and technical assistance opportunities.

Training. The initial training session with BC candidates provides an opportunity for reflection in which the women themselves, through discussion and guidance, come to an understanding of the characteristics of a BC and her role and responsibilities in the community. It is a *self-selection process* in which the woman decides whether or not she can meet the criteria of the position.

Support and nurturing. LLLG has learned that BCs need ongoing nurturing (similar to that provided to LLL leaders within the LLLI structure). LLLG provides this nurturing through positive feedback, demonstrated interest, support, guidance, and incentives. This includes monthly mini-workshops at the LLLG office and refresher courses in the communities that provide timely information on breastfeeding and various health-related topics.These meetings also help maintain unity and cohesion among the BCs. The annual workshop provides good motivation for both reporting and nonreporting counselors.

Breastfeeding Information System. The Breastfeeding Information System needs to be as simple as possible. The importance and utility of this system was brought home to the BCs during the annual workshop in 1996, and as a consequence the nonreporting BCs are now motivated to hand in their forms to their coordinator.

System of coordination: supervision and monitoring. LLLG's system of coordinators and subcoordinators elected from among the BCs in each community has helped the counselors to be self-reliant and independent in their own communities. The role of LLLG then is one of facilitator. *Decentralizing and placing responsibility at the community level allows the community to feel ownership of the project.*

Notes

1. Maza, I Ch. de, Magalhaes, R., and Stone-Jimenez, M. 1994. Sustainability of breastfeeding mother support groups in Guatemala. In: Storms, D., Carter, C., and Altman, P. (eds). *Community Impact of PVO Child Survival Efforts: 1985–1994*. Proceedings of a worldwide conference sponsored by USAID, Bangalore, Kanataka, India, October 2–7, 1994. Baltimore, Md.: The Johns Hopkins University School of Hygiene and Public Health. PVO Child Survival Support Program, pp. 67–70.

2. For every two children aged 1 year, there is an average of one woman between four and nine months pregnant.

3. UPAVIM is an organization formed by the women of La Esperanza. The initials stand for "United in Order to Live" in Spanish.

Appendix A. Household Survey in El Limón: Questionnaire No. 1

QID: _____

Date of interview ____/____/____

Name of interviewer _____ IID _____

Location of house: Sector _____ Block _____ Lot _____

Name of interviewee _____

Place of interview _____

Please mark with an X the letter or the designated space for the answer, or write the answer if prescribed.

1. How old are you? _____
   Mark: Woman of fertile age (15–49) No _____
   Yes _____

2. How many living children do you have? How old are they?

		Yes/No	How many?
a.	0–2 years	_____	_____
b.	3–5 years	_____	_____
c.	6–7 years	_____	_____
d.	Older than 7 years	_____	_____

3. On what date was your last child born? ____/____/____

4. Are you pregnant?
   No _____ (Go to question #6)
   Yes _____

5. How many months pregnant are you?
   a. 0–3 months
   b. 3–6 months
   c. More than 6 months

6. Has anyone ever spoken to you about breastfeeding?
   No _____ (Go to question #8)
   Yes _____ Do you remember when? a. Less than three months ago
   b. More than three months ago

7. Who has talked to you about breastfeeding? (If the interviewee only responds with a name, investigate who this person is or where she works.)
   Do you remember her name? _____

a.	Mother	b.	Mother-in-law
c.	Relative	d.	Midwife
e.	Neighbor	f.	Friend
g.	Personnel from NGO	h.	Personnel from Health Center

   i. Breastfeeding Counselor (Verify the name against the list of Breastfeeding Counselors.)
   j. Other _____

continued

8. Do you know if there is a woman or women who live near here who know a lot about breastfeeding?
   a. No, there isn't (Go to question #15)
   b. I don't know (Go to question #15)
   c. Yes, there is: What do they call her around here?
   _____

9. Do you know her/their name(s)?
   No _____
   Yes _____ Name(s): _____
   According to the list: Breastfeeding Counselor _____
   Is not a Breastfeeding Counselor _____

10. Has she at one time counseled you about breastfeeding?
    No _____ (Go to question #12)
    Yes _____ When? a. Less than three months ago
    b. More than three months ago

11. In what place or where did you meet when the two of you talked about breastfeeding? (Make note of the first place mentioned).
    a. At my house
    b. On the street
    c. At a Support Group
    d. Other _____

12. Do you know where this/these person(s) lives/live?
    No _____
    Yes _____

13. Have you ever looked for her/them to seek any advice?
    No _____
    Yes _____ When? a. Less than three months ago
    b. More than three months ago

14. Has this person ever come to your house?
    No _____
    Yes _____ When? a. Less than three months ago
    b. More than three months ago
    What was the reason for her visit? _____
    _____

15. Have you heard about the Support Groups for mothers and pregnant women here in the community? (Explain what they are, if necessary.)
    No _____ (Go to question #18)
    Yes _____

16. Who told you?
    Do you remember her name? _____
    a. Relative b. Neighbor
    c. Friend d. Personnel from some NGO
    e. Midwife f. Personnel from Health Center
    g. Breastfeeding Counselor (Verify the name against the list of Breastfeeding Counselors.)
    h. Other _____

continued

17. Have you ever gone to a Support Group?
    No _____
    Yes _____ How many times have you gone? _____
    When was the last time you attended a Support Group?
    a. Less than three months ago
    b. More than three months ago

*** Questions 18, 19, and 20 should be asked only if the woman has had contact with a Breastfeeding Counselor.**

18. * Has/have (name(s) of the Breastfeeding Counselor(s)) ever advised you to take your baby for medical attention? (Explain that it could be to the Health Center, an NGO that has a clinic, or a private clinic.)
    No _____
    Yes _____ Where were you when she gave you this advice?
    a. At a Support Group
    b. During a home visit
    c. During an informal counseling session
    d. Other _____
    When? a. Less than three months ago
    b. More than three months ago
    Why? a. Diarrhea
    b. ARI
    c. Malnutrition
    d. Well-Baby Clinic (Growth and Development)
    e. Immunizations
    f. Other _____
    And what did you do?
    a. Took baby for medical attentiion
    b. Did not take baby for medical attention

19. * Has/have (name(s) of the Breastfeeding Counselor(s)) ever advised you to seek medical attention?
    No _____
    Yes _____ Where were you when she gave you this advice?
    a. At a Support Group
    b. During a home visit
    c. During an informal counseling session
    d. Other _____
    When? a. Less than three months ago
    b. More than three months ago
    Why? a. Prenatal Care
    b. Child Spacing
    c. Other _____
    And what did you do?
    a. Went for medical attention
    b. Did not go for medical attention

continued

20. * Have you ever had the opportunity to give breastfeeding advice to another woman?
    No _____
    Yes _____ When? a. Less than three months ago
    b. More than three months ago

Ask all the women:

21. The house where you live is: a. Your own
    b. Rented
    c. Other _____

22. What kind of stove do you use for cooking?
    a. Wood b. Gas c. Electric d. Other _____

23. How do you obtain your water supply?
    a. Installation of running water (faucets inside the house)
    b. Own well
    c. Purchase (by the barrel, for example)
    d. Obtain from the river
    e. Communal faucet
    f. Other _____

24. Do you have?
    a. A toilet (flush system)
    b. Washable latrine (concrete slab)
    c. Outhouse
    d. Other _____

Observe the physical characteristics of their residence:

25. Material from which their residence is made:
    a. Brick or block
    b. Wood or slats
    c. Lamina
    d. Other _____

26. Type of floor:
    a. Dirt
    b. Cement slab
    c. Granite
    d. Other _____

Appendix B. Survey of BCs: Questionnaire No. 2

QID: _____
Date of the interview _____

Name of the interviewer _____ IID _____

Community _____

Name of the Breastfeeding Counselor _____

Address _____

General Information

1. How many living children do you have? How old are they?

		Yes/No	How many?
a.	0–2 years	_____	_____
b.	3–5 years	_____	_____
c.	6–7 years	_____	_____
d.	Older than 7 years	_____	_____
	Total		_____

2. How old are you? _____

3. Do you know how to read and write?
   No _____
   Yes _____

4. Up to what grade have you studied?
   a. No schooling
   b. Completed elementary school
   c. Not completed elementary school
   d. Completed high school
   e. Not completed high school
   f. Other _____

5. Do you have remunerated work outside the home?
   No _____
   Yes _____ Where? _____
   What? _____

6. Do you do some volunteer activity or work other than that of a Breastfeeding Counselor?
   No _____
   Yes _____ Where? _____

Characteristics of the Residence

7. The house where you live is:
   a. Your own
   b. Rented
   c. Other _____

continued

8. What kind of stove do you use for cooking?
   a. Wood b. Gas c. Electric d. Other _____

9. How do you obtain your water supply?
   a. Installation of running water (faucets inside the house)
   b. Own well
   c. Purchase (by the barrel, for example)
   d. Obtain from the river
   e. Communal faucet
   f. Other _____

10. Do you have?
   a. A toilet (flush system)
   b. Outhouse
   c. Washable latrine (concrete slab)
   d. Other _____

11. Material from which their residence is made:
   a. Brick or block
   b. Wood or slats
   c. Lamina
   d. Other _____

12. Type of floor:
   a. Dirt
   b. Cement slab
   c. Granite
   d. Other _____

Motivation

13. How did you decide to become a Breastfeeding Counselor?
   _____
   _____
   _____

14. How were you invited to the training?
   a. Invited by an NGO of her community
   b. Invited by the health sector (health center, post, hospital) of her community
   c. Invited by a Breastfeeding Counselor
   d. Invited by someone from her community
   e. Invited by someone outside of her community
   f. Other _____

15. What have you liked the most about being a Breastfeeding Counselor?
   _____
   _____
   _____

16. What have you liked the least about being a Breastfeeding Counselor?
   _____
   _____
   _____

continued

Activities of the Breastfeeding Counselors

17. When was the last time you had an informal breastfeeding counseling session? (Explain.)
    a. Less than three months ago (that is, during this year)
    b. More than three months ago (Go to question #19)
    c. Have not had informal breastfeeding counseling sessions (Go to question #19)

18. More or less, how many informal breastfeeding counseling sessions have you had during this year? _____

19. When was the last time you made a home visit?
    a. Less than three months ago (that is, during this year)
    b. More than three months ago (Go to question #21)
    c. Have not had informal breastfeeding counseling sessions (Go to question #21)

20. More or less, how many home visits have you made during this year? _____

21. When was the last time you referred someone for medical attention (health center, post, hospital)?
    a. Less than three months ago (that is, during this year)
    b. More than three months ago (Go to question #23)
    c. Have not had informal breastfeeding counseling sessions (Go to question #23)

22. More or less, how many referrals have you made during this year? _____

Active or Inactive Classification of Breastfeeding Counselor

23. When was the last time you helped to lead or led a Support Group?
    a. More than a year ago (Go to question #24)
    b. Less than a year ago Did you hand in or send your Support Group forms?
       No _____ (Go to question #24)
       Yes _____ (Is active Breastfeeding Counselor. Go to question #27)

24. Did you hand in your marked calendar sheets last year (you can include the months of this year)?
    No _____
    Yes _____ How many times did you hand in your calendar sheets?
    a. Less than three times
    b. Three times or more (Is active Breastfeeding Counselor)

If the Breastfeeding Counselor is inactive, ask her:

25. Do you still promote breastfeeding?
    No _____
    Yes _____ How? _____
    _____

26. Why could you not continue with the Support Groups?
    _____
    _____

continued

If the Breastfeeding Counselor is active, ask her:

27. What has motivated you to continue working as a Breastfeeding Counselor?
    _____
    _____
    _____

28. Are you a Breastfeeding Counselor Coordinator?
    No _____ (Go to question #32)
    Yes _____ Do you visit the Breastfeeding Counselors in your area?
    No _____ (Go to question #29)
    Yes _____ How often?
    a. Once/month
    b. Twice/month
    c. Other _____

29. How much time a month does it take you to perform your Breastfeeding Counselor and Coordinator activities?
    _____ hours

30. Do you participate in the monthly mini-workshops?
    No _____ Why? _____
    Yes _____ Why? _____

31. Have you participated in a mini-workshop this year?
    No _____ Why? _____
    Yes _____ How many times?
    a. Three
    b. Two
    c. One
    (Go to question #35)

32. How much time a month does it take you to perform your Breastfeeding Counselor activities?
    _____ hours

33. Do you receive visits from the Coordinator of your community?
    No _____ Why? _____
    Yes _____ How often?
    a. Once/month
    b. Twice/month
    c. Other _____

34. Do you feel support from the Coordinator of your community?
    No _____ Why? _____
    Yes _____ Why? _____

35. Do you feel support from La Leche League?
    No _____ Why? _____
    Yes _____ Why? _____

continued

36. Do you know that the Breastfeeding Counselors meet monthly in your community?
    No _____
    Yes _____ Have you attended one of these meetings in the course of this year?
    No _____ Why? _____
    Yes _____ Why? _____

Outreach of the Breastfeeding Counselors in the Community

Questions for the Breastfeeding Counselors of El Limón only.

37. How do you (did you) invite the women to the Support Groups?
    _____
    _____
    _____

38. Where do you (did you) hold your Support Groups?
    a. At your home
    b. At the health center
    c. At dinners
    d. At the "Patronato Pro-Nutrición"
    e. At the Salvation Army
    f. Others _____

39. From where do (did) the women come who attend (attended) your Support Groups? (Sectors or blocks, or places outside of El Limón; investigate.)
    _____
    _____
    _____

40. Other than the Support Group, where do you usually counsel mothers?
    _____
    _____
    _____

41. As a monitora have you had any relation with the health center or other organizations in your community?
    No _____
    Yes _____ In what way(s)? _____
    _____
    _____

Appendix C. Total Expenses, October 1988–June 1996

		OCT–DEC 1988	1989	1990	1991	1992	1993	1994	1995	JAN–JUNE 1996	
1. Staff	US$	430	13,797	24,193	34,196	45,380	14,025	9,530	12,228	7,111	160,890
	Quetzal	1,161	39,169	110,595	173,233	235,624	80,832	55,041	71,193	43,804	810,652
2. Materials development	US$	0	116	519	6,900	2,988	2,873	3,799	2,405	811	20,411
	Quetzal	0	313	2,688	34,950	15,635	16,510	21,759	14,083	4,973	110,911
3. Training	US$	0	525	1,004	1,108	1,755	223	854	964	287	6,720
	Quetzal	0	1,588	4,514	5,606	9,112	1,269	4,907	5,737	1,765	34,498
4. Communication	US$	17	509	1,066	1,701	1,846	1,142	836	839	476	8,432
	Quetzal	46	1,546	4,740	8,592	9,542	6,536	4,845	4,862	2,936	43,645
5. Rent	US$	0	0	1,750	1,750	1,575	1,221	1,074	1,235	586	9,191
	Quetzal	0	0	8,237	8,883	8,145	6,865	6,199	7,201	3,610	49,140
6. Materials	US$	0	100	176	472	767	325	447	219	165	2,671
	Quetzal	0	278	964	2,389	3,979	1,833	2,568	1,267	1,016	14,294
7. Office supplies	US$	27	265	491	1,117	807	568	189	391	181	4,036
	Quetzal	73	735	2,303	5,642	4,191	3,167	1,090	2,276	1,114	20,591
8. Services	US$	0	0	234	0	80	575	533	311	144	1,877
	Quetzal	0	0	977	0	425	3,318	3,077	1,826	884	10,507
9. National travel	US$	0	1,134	1,365	1,690	1,637	1,064	296	513	63	7,762
	Quetzal	0	3,241	6,335	8,541	8,523	6,085	1,699	3,042	389	37,855
10. International travel per diem	US$	0	1,646	2,166	2,022	3,297	0	0	0	0	9,131
	Quetzal	0	4,444	11,688	10,239	17,021	0	0	0	0	43,392
11. Utilities	US$	0	0	78	182	221	115	58	48	47	749
	Quetzal	0	0	375	922	1,152	631	333	278	289	3,980

continued

Appendix C. Total Expenses (cont.)

		OCT–DEC 1988	1989	1990	1991	1992	1993	1994	1995	JAN–JUNE 1996	
12. Professional training	US$	0	606	174	1,218	254	0	489	0	10	2,751
	Quetzal	0	1,636	813	6,139	1,303	0	2,844	0	62	12,797
13. Postage	US$	1	24	95	298	308	168	121	56	93	1,164
	Quetzal	3	66	424	1,511	1,583	955	696	319	572	6,129
14. Equipment	US$	0	622	1,533	1,336	1,841	185	0	0	386	5,903
	Quetzal	0	1,869	6,060	6,774	9,657	990	0	0	2,374	27,724
15. Consultancies	US$	0	907	1,183	3,590	7,076	0	0	0	0	12,756
	Quetzal	0	2,550	5,243	18,162	37,037	0	0	0	0	62,992
16. Evaluation	US$	0	0	253	0	2,112	148	0	0	0	2,513
	Quetzal	0	0	1,162	0	11,163	792	0	0	0	13,117
17. Other maintenance	US$	0	0	159	747	713	132	3	0	0	1,754
	Quetzal	0	0	816	3,787	3,702	759	17	0	0	9,081
18. Legal status strategic plan	US$	0	0	0	400	0	229	0	0	0	629
	Quetzal	0	0	0	2,032	0	1,225	0	0	0	3,257
19. Kitchen supplies	US$	0	0	0	0	0	16	46	100	58	220
	Quetzal	0	0	0	0	0	87	266	581	357	1,291

continued

Appendix C. Total Expenses (cont.)

		OCT–DEC 1988	1989	1990	1991	1992	1993	1994	1995	JAN–JUNE 1996	
20. Donation LLLI	US$	0	0	0	0	0	0	68	196	0	264
Donation ID	Quetzal	0	0	0	0	0	0	392	1,174	0	1,566
21. Case study	US$	0	0	0	0	0	0	798	0	3,067	3,865
BASICS	Quetzal	0	0	0	0	0	0	4,581	0	18,841	23,422
22. Locale/LAM	US$	0	0	0	0	0	0	0	1,347	0	1,347
	Quetzal	0	0	0	0	0	0	0	8,069	0	8,069
23. BF Clothes	US$	0	0	0	0	0	0	0	0	396	396
	Quetzal	0	0	0	0	0	0	0	0	2,427	2,427
Totals	US$	475	20,251	36,439	58,727	72,657	23,009	19,141	20,852	13,881	265,432
	Quetzal	1,283	57,435	167,934	297,402	377,794	131,854	110,314	121,908	85,413	1,351,337

Appendix D. Total Income in U.S. Dollars, October 1988–June 1995

		OCT–DEC 1988	1989	1990	1991	1992	1993	1994	1995	Total
1.	C.S. PROJECT	475	20,251	36,439	58,727	72,657	340	0	0	188,889
2.	IRH	0	0	0	917	10,543	16,949	2,770	4,303	35,482
3.	LLLI	0	0	0	0	0	0	3,601	0	3,601
4.	Wellstart	0	0	0	0	0	17,082	7,161	8,000	32,243
5.	AID-Guatemala	0	0	0	0	8,708	0	0	0	8,708
6.	UNICEF	0	0	0	0	7,814	0	0	0	7,814
7.	LDSC	0	0	0	0	0	2,500	0	0	2,500
8.	UPAVIM	0	0	0	0	0	2,790	1,932	626	5,348
9.	APROFAM	0	0	0	0	308	0	0	0	308
10.	CEIDEC	0	0	0	0	0	0	1,045	664	1,709
11.	Consultancies	0	0	0	0	0	435	708	430	1,573
12.	Hospital HHLL	0	0	0	0	0	0	461	0	461
13.	CEMACO	0	0	0	0	0	113	0	0	113
14.	WABA	0	0	0	0	0	0	490	0	490
15.	NGOs	0	0	0	0	0	400	0	605	1,005
16.	Cloth Banners	0	0	0	0	1,185	3,302	4,233	0	8,720
17.	Membership	0	12	21	10	216	223	243	228	953
18.	Interest	0	0	0	0	262	1,626	1,348	1,442	4,678
	Totals	475	20,263	36,460	59,654	101,693	45,760	23,992	16,298	304,595

Appendix E. Expenses by Major Categories, October 1988–June 1996

			OCT–DEC 1988	1989	1990	1991	1992	1993	1994	1995	JAN–JUNE 1996	Total
1.	Personnel	US$	430	13,797	24,193	34,196	45,380	14,025	9,530	12,228	7,111	160,890
		Quetzal	1,161	39,169	110,595	173,233	235,624	80,832	55,041	71,193	43,804	810,652
2.	Material Development	US$	0	116	519	6,900	2,988	2,873	3,799	2,405	811	20,411
		Quetzal	0	313	2,688	34,950	15,635	16,510	21,759	14,083	4,973	110,911
3.	Training	US$	0	525	1,004	1,108	1,755	223	854	964	287	6,720
		Quetzal	0	1,588	4,514	5,606	9,112	1,269	4,907	5,737	1,765	34,498
4.	Rent	US$	0	0	1,750	1,750	1,575	1,221	1,074	1,235	586	9,191
		Quetzal	0	0	8,237	8,883	8,145	6,865	6,199	7,201	3,610	49,140
5.	Materials	US$	0	100	176	472	767	325	447	219	165	2,671
		Quetzal	0	278	964	2,389	3,979	1,833	2,568	1,267	1,016	14,294
6.	Supplies	US$	27	265	491	1,117	807	568	189	391	181	4,036
		Quetzal	73	735	2,303	5,642	4,191	3,167	1,090	2,276	1,114	20,591
7.	Local Travel	US$	0	1,134	1,365	1,690	1,637	1,064	296	513	63	7,762
		Quetzal	0	3,241	6,335	8,541	8,523	6,085	1,699	3,042	389	37,855
8.	Utilities	US$	0	0	78	182	221	115	58	48	47	749
		Quetzal	0	0	375	922	1,152	631	333	278	289	3,980
9.	Office Equipment	US$	0	622	1,533	1,336	1,841	185	0	0	386	5,903
		Quetzal	0	1,869	6,060	6,774	9,657	990	0	0	2,374	27,724
10.	Other	US$	18	3,692	5,330	9,976	15,686	2,410	2,894	2,849	4,244	47,099
		Quetzal	49	10,242	25,863	50,462	81,776	13,672	16,718	16,831	26,079	241,692
	Totals	US$	475	20,251	36,439	58,727	72,657	23,009	19,141	20,852	13,881	265,432
		Quetzal	1,283	57,435	167,934	297,402	377,794	131,854	110,314	121,908	85,413	1,351,337

Appendix F. System of Community Information on Breastfeeding: Sample Form

									JAN 1–JUNE 1		
	1989	1990	1991	1992	Subtotal	1993	1994	1995	1996	Subtotal	Total
Breastfeeding Counselor*	25	69	84	92	92	58	55	55	55	55	55
Coordinator	0	0	0	12	12	12	12	12	12	12	
Support groups											
1. No. of groups	22	29	29	9	8	8	8				
2. No. of meetings	10	109	158	156	433	217	199	104	56	576	1,009
3. No. of new mothers	29	541	920	792	2,282	658	750	1,022	381	2,811	5,093
4. No. of pregnant women	7	202	402	217	828	281	771	660	310	2,022	2,850
5. No. of mothers breastfeeding	24	526	1,088	1,054	2,692	1,077	1,196	848	379	3,500	6,192
6. Total no. of women	74	1,530	1,917	1,808	5,329	1,827	2,767	3,756	1,829	10,179	15,508
Counseling											
1. Individual counseling	NA	728	10,225	11,231	22,184	5,601	7,100	4,005	1,778	18,484	40,668
2. Home visits	NA	NA	NA	NA	NA	NA	442	427	869	869	
Referrals											
1. ARI	NA	NA	324	416	740	571	122	147	134	974	1,714
2. Growth and development	NA	NA	371	441	812	917	930	1,041	752	3,640	4,452
3. Immunizations	NA	NA	448	465	913	394	144	259	253	1,050	1,963
4. ORT	NA	NA	370	403	773	516	144	412	322	1,394	2,167
5. Malnutrition	NA	NA	285	446	731	282	190	182	187	821	1,552
6. Prenatal care	NA	NA	505	593	1,098	485	396	355	315	1,551	2,649
7. Child spacing	NA	NA	337	518	855	417	340	207	253	1,217	2,072
Totals	0	0	2,640	3,282	5,922	3,582	2,266	2,603	2,196	10,647	16,569

* Breastfeeding Counselor=active.

Note: NA= not available